3-0900-16273-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE COMMISSIONER OF HEALTH

In the Matter of Bryn Mawr Health Care Center

RECOMMENDED DECISION

The above matter is the subject of an independent informal dispute resolution (IIDR) proceeding before Administrative Law Judge Kathleen D. Sheehy. Bryn Mawr Health Care Center (the facility) requested that the recommended decision be based on written submissions in lieu of a meeting. Based on this request the parties agreed to a schedule for submission of written materials. The OAH record closed on December 14, 2004, upon receipt of the last filing by the facility.

Sue Jackson, Assistant Director, Office of Health Facility Complaints, Division of Facility and Provider Compliance, 85 East Seventh Place, Suite 300, P.O. Box 64970, St. Paul, MN 55164, appeared for the Department of Health.

Susan M. Schaffer, Esq., Orbovich & Gartner, 408 St. Peter Street, Suite 417, St. Paul, MN 55102, appeared for the facility.

NOTICE

Under Minn. Stat. § 144A.10, subd. 16(d)(6) this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects this recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the following Memorandum, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

The deficiency, F309, is supported in substance. The citation is supported, but certain findings should be deleted as indicated below.

Dated this 28th day of December 2004.

/s/ Kathleen D. Sheehy
KATHLEEN D. SHEEHY
Administrative Law Judge

MEMORANDUM

The Department completed a standard abbreviated survey on October 12, 2004, as a result of a complaint concerning care provided to one patient by the Bryn Mawr Health Care Center. The Department issued a deficiency citation for one tag, F309, finding the deficiency to be isolated at severity level D, no actual harm with potential for more than minimal harm that is not actual jeopardy. The facility disputes this citation.

The deficiency citation alleged that the facility failed to comply with 42 C.F.R. § 483.25, which requires that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, the Department alleged that the facility failed to provide the necessary care and services to attain or maintain the highest practicable well being for one of two residents who were receiving the medication Coumadin (a blood thinner).[1] In support of this deficient practice the Department made a finding that after the resident was transferred to the facility, she did not receive Coumadin as ordered by her physician.[2] The Department now concedes that the physician did not order Coumadin to be administered to the resident; it maintains, however, that the facility failed to follow up with the physician to clarify whether Coumadin should have been administered to the resident.

With this concession the relevant facts are mainly undisputed. The resident was admitted to the facility on August 12, 2004 after surgery to relieve spinal cord compression. The hospital Patient Care Transfer form, which was sent to the facility with the resident, identified a primary diagnosis of spinal cord lesion/compression fracture and secondary diagnoses of aspiration pneumonia, schizophrenia, DVT, hyperglycemia, osteoporosis, and dysphagia.[3] DVT means deep vein thrombosis, a condition in which a blood clot formed in a lower extremity puts a person at risk for a life-threatening pulmonary embolism. Persons at risk for DVT are administered anticoagulants such as Coumadin, which increase the clotting time of the blood. Coumadin is a drug with a narrow therapeutic index (NTI), which means that a therapeutic dose is close to a toxic dose. In persons just starting anticoagulation therapy, the medication is titrated to a specific blood level through frequent use of blood tests, one of which is called an International Normalization Ratio (INR), until a maintenance dose is determined.[4]

The Patient Transfer form also listed approximately one dozen medications to be administered to the resident, including “Coumadin per Dr. Salita” with a reference to “(see [history] below)—none 8/12.” The treatment orders section of the form provides that an INR test had been performed August 10, with a result of 1.8; on the same date, the resident received 3 mg of Coumadin. An INR performed on August 11 had a result of 2.3; on that date the resident received 4 mg of Coumadin. An INR performed on August 12 had a result of 2.5, and the resident received no Coumadin that day. The form further indicated that INR should be checked on August 13.

The nurse who was on duty when the resident arrived at the facility reviewed and transcribed these orders. The nurse called the physician and spoke to him to clarify which diagnosis corresponded to each of the medications ordered. The nurse asked

the physician about the Coumadin and indicated that an INR had been ordered for the next day. The physician said he would look into the reason for prescribing Coumadin and would get back to the facility.

The next morning, August 13, 2004, the INR was performed, and the laboratory reported a result of 1.7. The laboratory form indicates that for prevention and treatment of DVT, the INR should be between 2.0 and 3.0.[5] The nurse on duty during the day called the result to the physician's clinic during the early afternoon and left a message with the patient's name and test result.[6] The day nurse informed the evening shift nurse that the INR results had been called to the clinic and that she was waiting for clarification of several other orders from the physician.[7]

The physician called at about 4:30 that afternoon. The evening shift nurse went through the other orders with the physician, which concerned the use of an abdominal binder and Posey foot guard. The physician said nothing about the INR result or the need for Coumadin; nor did the nurse ask whether Coumadin was necessary in light of the INR result.[8] The nurse assumed that the physician would have ordered Coumadin if he had thought it were necessary.[9] The resident received no Coumadin that day or for the next two days, during which the resident appeared to be doing well. On the morning of August 15, 2004, nursing staff found the resident suddenly unresponsive and barely breathing in her bed. Paramedics took her to the hospital, where she died four days later of respiratory failure. There is no evidence that the resident had a pulmonary embolism from DVT or that the failure to administer Coumadin contributed to her death in any way.[10]

The Department contends that the facility failed to clarify whether orders for Coumadin were needed, and that this constituted a failure to provide necessary care and services within the meaning of the regulation. The facility contends that it did seek and obtain clarification of the orders concerning Coumadin and that it was the physician's responsibility to order the medication if it were needed.

The facility's arguments are overstated. The facility did call the physician for clarification of orders concerning Coumadin administration on August 12, 2004, and the facility did call with the results of the INR test on August 13, 2004; however, when the physician returned the call to the facility later that day and addressed a variety of other issues, the staff did not follow through to obtain the necessary clarification about the need for Coumadin in light of the INR result. It is a semantic, as opposed to substantive, response to say that the physician's failure to specifically address the medication in this conversation was an adequate "clarification" of the resident's need for it.

The facility also argues that because the Department concedes that the deficiency erroneously states that the resident was not administered Coumadin "as ordered by her physician," the deficiency must be dismissed because the findings do not support it. The statute governing IIDR proceedings provides in relevant part as follows:

Within ten working days of the close of the arbitration proceeding, the administrative law judge shall issue findings regarding each of the deficiencies in dispute. The findings shall be one or more of the following:

(1) Supported in full. The citation is supported in full, with no deletion of findings and no change in the scope or severity assigned to the deficiency citation.

(2) Supported in substance. The citation is supported, but one or more findings are deleted without any change in the scope or severity assigned to the deficiency.

(3) Deficient practice cited under wrong requirement of participation. The citation is amended by moving it to the correct requirement of participation.

(4) Scope not supported. The citation is amended through a change in the scope assigned to the citation.

(5) Severity not supported. The citation is amended through a change in the severity assigned to the citation.

(6) No deficient practice. The citation is deleted because the findings do not support the citation or the negative resident outcome was unavoidable. …[11]

In this case, the citation is supported in substance. The deficient practice identified was the failure to provide necessary care and services to attain or maintain the highest practicable well being for a resident receiving Coumadin. Because the Department no longer relies on the findings concerning the physician's order for Coumadin and the findings concerning interviews with Physician D and Physician D's medical assistant (on pages 1 and 3 of the Statement of Deficiencies, respectively) those findings should be deleted. The remaining findings are sufficient to support the substance of the deficient practice. Because there is no evidence that the failure to obtain clarification on the need for this medication caused any harm to the resident, the scope and severity levels (D, isolated, no actual harm) are appropriate.

K.D.S.

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[1] Department Ex. 002.
[2] *Id*.
[3] Ariwoola Aff. Ex. A.
[4] *See* Survey Protocol for Long Term Care Facilities, F333 at PP 130.
[5] Department Ex. 006.

[6] Wolter Aff. Ex. C.
[7] Ariwoola Aff. ¶ 7; Wolter Aff. ¶¶ 8-9.
[8] Ariwoola Aff. ¶ 8.
[9] Ariwoola Aff. ¶ 8.
[10] Abbey Aff. ¶11, MDH File at 233-237
[11] Minn. Stat. § 144A.10, subd. 16(d).